North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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February 12, 2003

MEMORANDUM

TO: Area Program Directors
           Area Program Board Chairs
           North Carolina Council of Community Programs
           County Managers
           County Commission Chairs
           North Carolina Association of County Commissioners
           Legislative Oversight Committee Members
           Consumer/Family Advisory Committee Chairs
           Advocacy Organizations and Groups
           Provider Organizations
           MH/DD/SAS Professional Organizations and Groups
           MH/DD/SAS Stakeholder Organizations and Groups
           Other MH/DD/SAS Stakeholders

FROM: Richard J. Visingardi, Ph.D.

RE: **COMMUNICATION BULLETIN # 007**
           Best Practice- Adult Mental Health

State Plan 2002 Communication Bulletin

A.   Introduction

The state plan requires that services to target populations reflect best practice. The state plan also requires that services be provided and developed within a Recovery orientation. This communication bulletin is to provide clarification on these issues as they relate to the adults with severe and persistent mental illness (SPMI). Specifically, it will address:

▪ Elements of a Recovery orientation as it relates to support and service provision.

▪ Person-centered planning as supporting an individual's life.

▪ How recovery and supports and services must be integrated to create a *system* of best practice.

▪ Best practice services for adults with severe and persistent mental illness.

B. Recovery Oriented Supports and Services

The concept of Recovery is the foundation of all system efforts and best practice models. There are five essential elements of Recovery:

- Instillation of hope, a positive sense of self, and a positive outlook for the future.

- Focus on strengths.

- Empowerment.

- Self-Determination.

- Meaningful work and roles in life.

Recovery oriented supports and services facilitate a process whereby consumers define their strengths and goals and create meaningful lives and roles beyond that of "psychiatric patient". Recovery oriented supports and services incorporate a tolerance for "set backs", understand that the recovery process is not simple or linear and are provided in a care environment that is flexible enough to allow for the ups and downs of the illness. In a recovery framework, clinical decisions are evidence based, but always in the context of partnership and person-centered planning, which requires personal choice and a match of supports and services that respects individual needs and goals. Research has demonstrated that this approach results in positive treatment outcomes and high client satisfaction.

The illustration below shows the way in which the concept of Recovery for adults with severe and persistent mental illness is essential to implementing reforms that are consistent with the State Plan vision and principles.
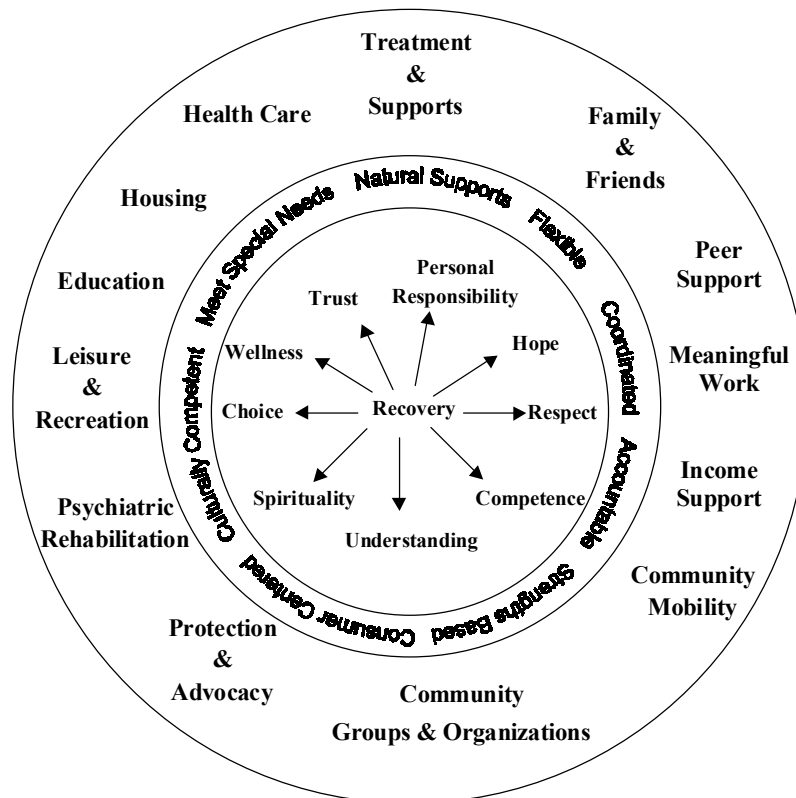
C. Person-Centered Planning

Person-centered planning is not a program. Person-centered planning is a life planning method (process) of determining real life outcomes (ends) for individuals and developing strategies (means) to achieve these life outcomes. There are three key implications of person-centered planning.

1. **Process:** There are four models of practice that are recognized as legitimate, person-centered planning methods: Essential Lifestyle Planning (ELP), McGill Action Planning System (MAPS), Personal Futures Planning (Futures) and Planning for Alternative Tomorrows (PATH). A particular method is chosen based on an individual's life circumstances, situation and condition.

   All of these methods have key similarities. They all involve a process of negotiation. They all dynamic; they occur on an "as needed" basis. Also, they all use a quality improvement process that involves continuously monitoring progress and using the resulting information and data to continuously improve the plan to assure the achievement of desired outcomes. In addition, any legitimate person-centered planning process contains certain core components. The person-centered planning process must:

   - Be driven and owned by the individual with the disability.

   - Involve a sustained commitment to the life of the individual with the disability.

   - Be strengths-based.

   - Include a crisis contingency plan.

   - Include reasonable assurances of health and safety.

   - Contain strategies that reflect the most natural, durable and sustainable methods of achieving the outcomes.

   - Be "real life" outcome oriented.

2. **Real life outcomes:** Real life outcomes are defined as related to life domains and are intended to reflect the most natural, durable and sustainable life of an individual – community inclusion. Examples include housing, career and vocational, educational, health, clinical, social, intimate relationships, friendships, spiritual, civic and economic dimensions. The number of life domains that need to be addressed at any point in time may vary, but as many as possible should be examined. In addition, strategies to address life domains should include consideration of how strategies can be integrated around the individual as well as how individual outcomes may be integrated with other outcomes (developing relationships and employment, as examples).

3. **Strategies:** Strategies are the methods that are intended to promote the achievement of the outcomes. Strategies are to be considered in the following order:

   - **Personal resources:** Financial resources possessed by the individual. This does not include driving people further into poverty.

   - **Natural supports:** People most closely associated with the individual, including other adults with severe and persistent mental illness. This does not include "dumping" on natural supports.

- **Natural community resources:** People, places, social institutions and systems available to all people in the community. This does not include "dumping" on the community.

- **Specialty community resources:** People, places, social institutions and systems that are specifically intended and designed for accommodating and supporting people with disabilities. This includes other entitlements, designated resources and other legally oriented provisions (housing, school and vocational, as examples). This does not include inappropriate "cost shifting" in any direction.

- **Specialty supports and services:** Publicly sponsored provisions of support, service and treatment.

It is critical that the development of the person-centered plan does not become the outcome. The person-centered plan is the map that guides the individual and his/her natural supports, personal and community resources and publicly sponsored specialty supports, services and treatment to move towards his/her real life outcomes.

D.   Integrated System of Supports and Services

The information that follows pertains to systems providing supports, services and treatment for the population described in this communication.

Growing out of a Recovery approach and person-centered planning is an array of *integrated* supports and services to support recovery. Without this integration, including a single point of accountability, consumers will continually "fall through the cracks" of a fragmented system. This integrated service model is very distinct from a single provider practice model and in most cases closer to a multi-service agency. In some cases, all services are provided under one roof or agency (single agency model). In other cases the services needed are coordinated by a clear point of accountability through an organized comprehensive integrated community provider network system. Three types of examples of an organized system are as follows:

- **Lead arrangement:** A single provider organization is the lead entity and maintains formal relationships with a network of other provider organizations. The lead provider organization is the agency responsible for ensuring the implementation and management of the person-centered plan. As a whole, the network contains the comprehensive array of supports and services.

- **Affiliated arrangement:** A group of provider organizations formally comes together to develop a comprehensive network. This includes a range of ways to organize including the development of an administrative services organization (ASO), as an example.

- **Relational arrangement:** As part of a condition for contracting with the LME, each individual provider organization agrees to maintain a relationship with all of the other individual provider organizations in the network.

The above examples are not exhaustive. There are a variety of ways an organized system can be approached. The uniqueness of each community is the key factor considered in determining the systems configuration. In addition, the above examples are incomplete and oversimplifications.

Service definitions and provider qualifications, specified by the state, can be expected to incorporate these examples. Reimbursement mechanisms established by the State can be expected to recognize and incentivize these examples. In addition, LME provider network

development responsibilities and LME responsibilities for entering into provider contracts will also reflect the specific form of the organized provider network(s) and system. The LME "network" is not in and of itself *one* of these examples of forms. Rather, the LME provider network is comprised of the entire panel of providers; many, if not most, will be organized in a manner similar to these examples and augmented by private practitioners, as necessary.

As LMEs proceed to divest themselves from providing direct services, while at the same time seek to encourage new and different private provider organizations to come forward in a manner consistent with these examples, it is important to keep in mind that these examples include the preferred characteristics of entities forming the new provider panel doing business with the LME in its local system management role. Regardless of the organized provider network system design and used, the following are the essential elements of the design:

- **Integrated:** Each provider organization is expected to maintain relationships as part of a network responsible for delivering supports and services. The network is a constellation of provider organizations – a system.

- **Coordinated:** All aspects of a person-centered plan are to be carried out by the provider organization in such a manner that reflects the interrelationship of each individual component of the plan.

- **Comprehensive:** A network should be comprised of a full complement of supports and services. This includes regional efforts to satisfy availability of scarce demand types of services. A system should be comprised of more than one network.

- **Community:** Each provider organization should have a viable and valued role as part of the local community.

At the core of this system are the individuals or teams responsible for implementing and managing the person-centered plans; this is frequently a component of case management services. Many, but certainly not all, consumers require case management services. Many consumers with severe and persistent mental illness can benefit from blended, active, service-oriented and skill-building case management models. These services can be integrated with other services for these consumers, sometimes into a single service definition, under a reimbursement methodology that includes the case management function with payment for the other services. For example, many consumers with severe and persistent mental illness will require a form of intensive case management or will require Assertive Community Treatment (ACT).

To achieve this single point of accountability and service integration, services for adults with severe and persistent mental illness are best coordinated using a single multi-service agency or multiple-agency network where the ACT team or the provider agency's case manager serves to coordinate the array of support services. The case manager is usually a member of the team. Thus, the provider organization providing intensive case management or ACT is the ultimate accountable agency. Following required protocols (medical necessity and federal sufficiency standard, as examples), case managers and ACT teams should be empowered to make decisions and develop comprehensive treatment plans with consumers that are then submitted to the LME for approval.

The array of supports and services that are part of the organized provider network system (integrated system) fall into a number of domains:

- Mental health treatment.

- Crisis response services.

- Health and dental care.

- Housing.

- Vocational.

- Peer support.

- Family and community support.

- Rehabilitation services.

INTEGRATED SYSTEM

Crisis Response Services

Health and Dental Care

Mental Health Treatment

ACT

Consumers

Residential Stability

Case Management

Rehabilitation Services

Vocational

Family and Community Support

Peer Support
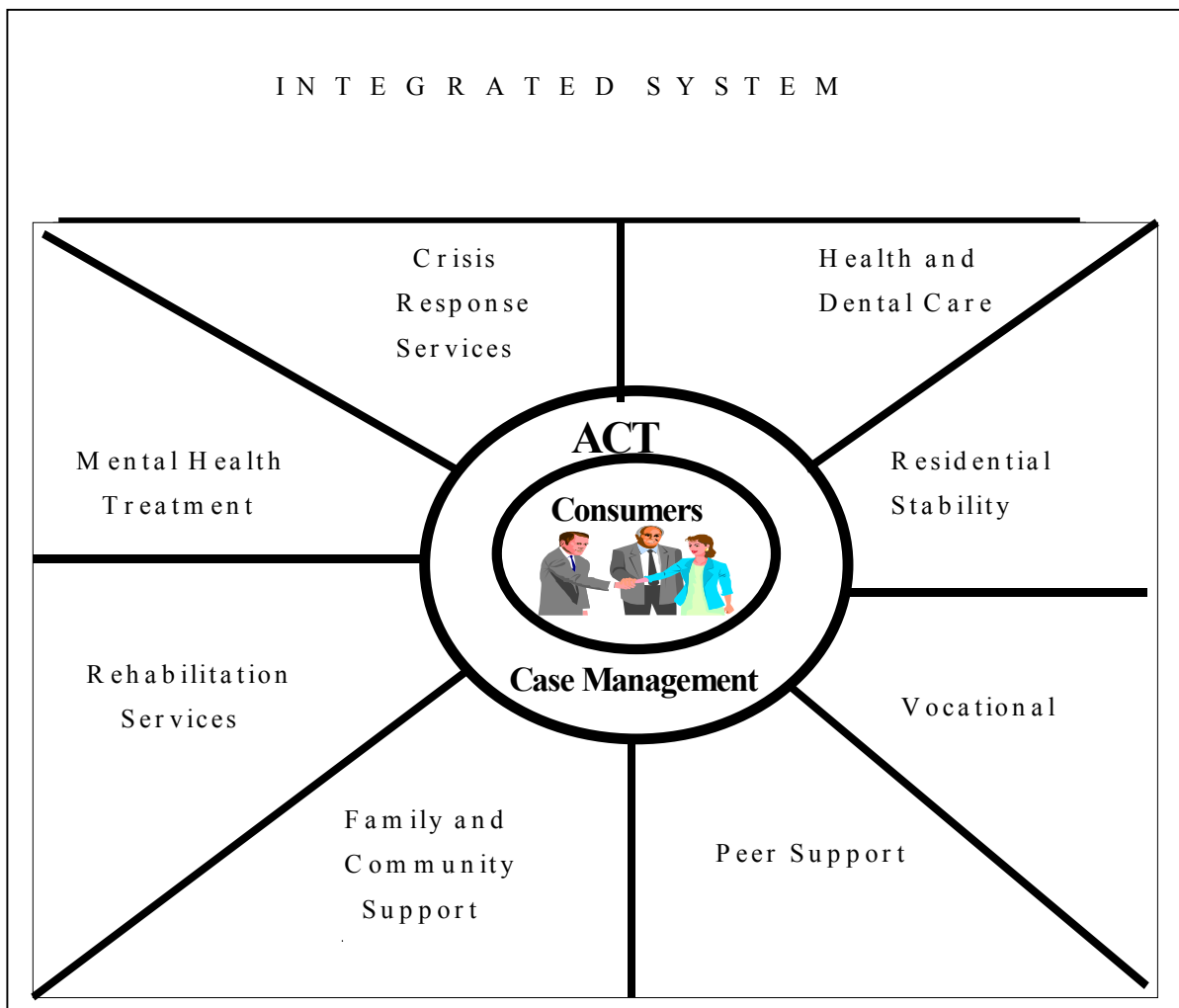
Each dimension has a number of discrete services. These services are listed below. The Division recognizes that our current system of services does not offer all components of this array of services uniformly across the state and LMEs will not be required to offer all services in the immediate future. At the same time, the Division is working to include a number of these kinds of services in a new service taxonomy that may become eligible for federal financial participation through Medicaid as well as state funds. This work includes clarifying service definitions, provider qualifications and reimbursement methodologies.

As the service taxonomy is developed, stakeholders will have the opportunity to have input. As Medicaid and state fund reimbursement policies are adjusted to conform to the new service definitions and as provider organizations demonstrate their capacity to provide these services, the Division expects that LME systems will include more of these providers and services. This memorandum will guide the work the state is doing to better align funding, requirements and best practices. LMEs should, however, at a minimum, offer at least one service in each dimension through their provider network. (Dimensions are presented in Section E. Best Practices Supports and Services.) This should reflect the service most consistent to the needs of the population. The continued LME strategic planning should also reflect how the LME would continuously work with its provider networks to develop, over time, the array of services across dimensions.

E.   Best Practice Supports and Services

There is remarkable consensus around "best practice" supports and services for adults with severe and persistent mental illness. Those best practice services that have empirical evidence of efficacy are considered to be "evidence based practice". A national project supported by the Robert Wood Johnson Foundation has developed a series of evidence-based practice (EBP) tool kits. The EBP tool kits include sections for administrators, practitioners, consumers and families. They include training modules and they include evaluation instruments to assess fidelity to the model of practice. It is the intent of the Division that the services identified through the EBP tool kits are a priority. As soon as the tool kits are available to providers, the LMEs should utilize the tool kits in the development of these services, provide training based on the tool kits and utilize the evaluation tools through the LME's quality improvement responsibility to ensure fidelity to the model of service throughout the provider network.

Services for which EBP tool kits are available are:

- Medication management.
- Illness self-management.
- Integrated dual disorder treatment.

- Supported employment.
- Family psycho-education.
- Assertive community treatment.

Additional information regarding these six evidence based practices is available at http://mentalhealthpractices.org and other web sites listed in the final section of this communication (Section G. Resources).

While these evidence based practice services should be given priority, they do not constitute the full array of best practice services. A list of best practice services by dimension is shown on the following pages. Essential elements of a best practice service are listed as well as characteristics of individuals who benefit most from this particular service. Services that have an EBP Tool Kit available are indicated with ***.

DIMENSION: CASE MANAGEMENT/ACT

Intensive Case Management	
Essential Elements	**Who Benefits**
- Consumers are linked with all services, benefits and entitlements for which they qualify and that they choose to receive. - Case manager helps with application process and advocates for entitlements, if consumer experiences a barrier to service or entitlement access, and monitors ongoing connection between consumer and entitlement/service. - Case manager also partners with consumer to help connect with natural community supports and resources. - Case manager to consumer ratio is maintain at approximately 1:25-30. - Case management is provided within the context of a partnership relationship; the case manager provides support and problem-solving assistance, as needed. - Case management occurs through community-based (rather than office based) contacts. 24/7 crisis response capacity for individuals being provided case management services.	Consumers with severe and persistent mental illness with multiple and/ or complex needs.

Assertive Community Treatment Teams***	
Essential Elements	**Who Benefits**
- Services provided by a team that is responsible for all client needs. - Team members share responsibility for all clients. - High team member to client ratio (roughly 8-10 clients per team member). - Services provided in clients' natural setting. 24/7 coverage including as related to crisis response capacity for individuals being provided ACT services. - Shared caseloads among team members. - Flexible direct services. - Broad team skills and training (team has a psychiatrist, vocational specialist, nurse, SA specialist, etc.). - Client advisory mechanisms that provide oversight of the service.	- Clients with high utilization: - Long periods in the hospital - Frequent hospitalizations - Repeated emergency room visits - Clients with severe impairment in psychosocial functioning. - Homeless clients. Financiers of mental health services. (ACT services can be expensive, but they save money by decreasing the use of even more costly services such as hospitalizations, ER visits, etc.) - Some clients feel ACT teams are too intrusive and paternalistic. This may relate to how an ACT team is implemented, although more research is needed.

DIMENSION: MENTAL HEALTH TREATMENT

Medication Management***

Essential Elements	Who Benefits
• Rational step-wise, evidence-based approaches to symptom management. • Algorithms to approach the severe mental disorders.	• Clients receive state-of–the art medication management. • Clients are assured that treatment is based on a common knowledge base across the state.

Assessment

Essential Elements	Who Benefits
• Telephone contact with clinician, and capacity for face-to-face 24/7, with contact for emergency care within 1 hour; urgent care w/in 48 hrs. and routine care within 7 days. • Should be done by a qualified professional receiving regular supervision, cross-trained in adult MH and SA across all age groups (i.e. young adult, adult, geriatric). • Must have access to psychiatrists, clinicians with expertise in MR/DD, and interpreters as needed, with explicit criteria for when these professionals are consulted. • Screening results in triage for determination of 1) emergent, urgent, or routine care; 2) appropriate and timely clinical referrals; 3) immediate medical evaluation; and 4) referral to social supports. Assessment verifies these determinations. • Assessment results in a diagnosis., case formulation, and initial treatment plan. • Assessment includes all clinically relevant information from the following areas: 1) chief complaint/ reason for referral; 2) history of present illness; 3) past MI/DD/SA history – with particular awareness for potential multiple disorders such as MI/SA; 4) mental status exam; 5) medical history; 6) substance abuse history; 7) family/marital/ relationship history; 8) psycho-social /developmental history; 9) involvement with criminal justice system; 10) occupational history; 11) educational history; 12) functional assessment, including ability to complete activities of daily living; 13) potential barriers to treatment; 14) strengths and resources; 15) socio-cultural diversity issues.	• All clients seeking mental health services. • All individual receiving mental health services.

Illness Self-Management***	
Essential Elements	**Who Benefits**
• Psycho-education about illness including diagnosis and symptoms, effects of medication, stress-vulnerability model, effects of alcohol and drugs. • Allows avoidance and minimization of relapses through recognition of early warning signs of relapse, avoidance of alcohol and drugs, regular sleep and exercise • Promotes interdependence between the individual and treatment and service providers.	• Likely all clients. • Clients at risk of symptom exacerbation, re-hospitalization and relapse have been shown particularly to benefit.

Integrated Dual Disorder Treatment***	
Essential Elements	**Who Benefits**
• Concurrent treatment of mental illness and substance abuse by the same clinicians who assume responsibility for treating both disorders. • Key features include assertive outreach, stage-wise treatment, harm-reduction approach, counseling, motivational interventions and social support interventions. • Must be linked with comprehensive mental health services, culturally sensitive and focused on long-term goals and recovery.	• Likely to benefit all individuals with co-occurring disorders. • Research and state reform efforts thus far have focused on individuals with serious mental illness and co-occurring substance use disorders. • About 50% of individuals with serious mental illness have a co-occurring substance use disorder. **Dual disorder treatment is very important.**

DIMENSION: CRISIS RESPONSE SYSTEM

Crisis Response System	
Essential Elements	**Who Benefits**
• May be provided by a mobile team that provides in-home or community-based crisis responses and resolution services. • Staffed by multidisciplinary treatment team. • An alternative or complementary model utilizes community crisis centers staffed with multi-disciplinary teams with observation or brief stay capability.	• Mobile crisis teams, by intervening in the community, mobilize existing supports and minimally disrupt client lives. • Some crises can not be resolved by mobile teams and require more intensive management. • Crisis units have the advantage of providing more intensive, medically supervised care.

DIMENSION: REHABILITATION SERVICES

Rehabilitation Skill Teaching	
Essential Elements	**Who Benefits**
• Establishing a partnership between service provider and consumer. • Helping the consumer choose a role and setting in which s/he would like to live, learn or work. • Identifying the skills and resources needed to be successful. • Helping the consumer learn the skills needed to reach goals & linking the person with the support/resources needed for success. • Can be done individually or in groups. • Should occur over several months.	• Individuals with severe and persistent mental illness with interest in employment, independent living and/or education. • Rehabilitation skill teaching has been shown effective in increasing consumer job skills, ability to live independently and leisure time activities for consumers.

Social Skills Training	
Essential Elements	**Who Benefits**
• Modeling, role playing, positive and corrective feedback, homework use social learning principles to teach social skills. • Multiple weekly sessions. • Individual and group formats. • Training lasts 3 mos. to over a year. • Training occurs in client's natural setting.	• Most research on social skills training has been done in individuals with schizophrenia. • Research suggests that any client with poor social functioning could benefit from social skills training.

DIMENSION: FAMILY AND COMMUNITY SUPPORT

Family Psycho-education***	
Essential Elements	**Who Benefits**
• Multiple successful formats (single or multiple family sessions; locations include clinics, homes, family practices & other community settings; techniques include didactic, cognitive-behavioral, and systemic). • Longer, more thorough programs are more successful to a point. • Key element of psychoeducation is its focus: it must be on expectations and common goal setting, social and clinical needs, education needs, communication needs, family strengths and weaknesses, stress-reduction, problem-solving, coping, crisis plans, skills training and other support. • Oriented to future, not to past.	• Clients in regular contact with relatives more than 4 hours per week. • Clients with time and resource intensive needs: emotional support, case management, financial assistance, advocacy, housing, etc. • Clients with little support outside of their family. • Benefits of family psychoeducation confirmed for a broad range of disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, obsessive-compulsive disorder, anorexia nervosa and borderline personality disorder.

DIMENSION: PEER SUPPORT

Mutual Support Groups	
Essential Elements	**Who Benefits**
- Consumers share support, hope, skills and problem solving strategies with other consumers. - Voluntary and consumer run, without mental health professional leadership.	- People with severe and persistent mental illness wishing to connect with others around recovery. - Research has shown that members of mutual support groups report increased hope and self-understanding, longer community tenure and increased social integration.

Consumer Providers	
Essential Elements	**Who Benefits**
- Consumers work in mental health settings (often as case managers), or have independent consumer run programs such as drop-in centers, employment programs or residential programs. - Consumer providers are paid employees, with more formalized infrastructure and interaction with consumer clients than in mutual support groups.	- People with severe and persistent mental illness receiving or desiring community based services. - Provides consumer employees with meaningful social and professional roles. - Services and programs provided by consumers have been shown to be as effective as professionally provided services, often result in higher consumer client satisfaction, and sometimes reported better outcomes than professionally provided services.

DIMENSION: RESIDENTIAL STABILITY

Housing	
Essential Elements	**Who Benefits**
• Independence: 1) People choose their housing, including location and model; 2) leases or occupancy agreements clearly outline tenant rights and responsibilities; 3) the provision of services is distinct from the housing. • Affordability: Tenants should not have to pay more than 30% of income for housing costs. • Accessibility: Must meet a range of accessibility needs including being physically accessible, being accessible to needed services and close to public transportation. • A range of housing options should be available including permanent and transitional housing, building- specific and scattered-site housing and housing ranging from single occupancy to shared living space.	• All individuals with severe and persistent mental illness need safe and stable housing. • No one model of housing meets the needs of all people with mental illness.

Jail Diversion	
Essential Elements	**Who Benefits**
• Case management. • Training to work with individuals with mental illness. • Ongoing collaboration with local criminal justice for diversion as early as possible. • Aggressive identification of appropriate cases within the first 24-48 hours of detention. • Data systems to track individuals through criminal justice and mental health systems.	• While many programs only focus on the person after an arrest, greater success occurs from providing alternatives to arrest such as improved police training, more 24-hour assistance centers and expansion of supportive housing programs.

DIMENSION: VOCATIONAL

Supported Employment***	
Essential Elements	**Who Benefits**
- Focus on and commitment to competitive work. - Rapid job search and placement. - De-emphasis on pre-vocational training & assessment. - Attention to client preferences. - Places all who desire employment, regardless of disability or skills. - Follow-along supports provided indefinitely. - Integration with case management and clinical services.	- Supported employment is the most effective vocational rehabilitation approach for all persons with mental illness, regardless of work experience or disability. - But, individuals with prior work history have better outcomes. - Clients interested in competitive work.

F. Other Critical Areas

The following areas should also be provided particular attention as part of the supports and services for adults with severe and persistent mental illness:

- **Physical Health:** Many clients with severe and persistent mental illness lack a regular medical provider, despite the recognition that many clients have, or are at risk for, serious physical health problems. Many clients have poor and risky health practices include poor diet, lack of physical exercise, smoking, illegal drug use and unprotected sex. Clients are at risk for a number of poor health outcomes including HIV, STDs, hepatitis, breathing problems, etc. that predictably result in excess mortality and morbidity. Providers should actively link clients to medical providers, regularly counsel clients about behaviorally-related health risks and work with medical providers to coordinate medical and mental health care. Mental health providers are encouraged whenever possible to provide on-site medical services to reduce barriers to medical care.

- **Psychiatric Inpatient:** Best practice models include alternatives to episodes of inpatient psychiatric care. However, individuals may require periodic psychiatric hospitalizations. It is imperative that the process of discharge planning initiate with the admission. This includes efforts intended on maintaining resources in the community to prepare for the person's discharge (housing, as a key example). Furthermore, the discharge itself should be a planned effort that ensures community supports and services are in place so the individual may connect with needed services immediately upon discharge. The person-centered plan crisis contingency component should address episodes of inpatient psychiatric care from admission to discharge.

- **Clubhouse Models:** Clubhouse models such as psychosocial rehabilitation (PSR) and Fountain House provide an effective structure through which a number of best practices can be offered and integrated. For example, clubhouse models offer a structure for rehabilitation services and peer support. In planning the integrated system, the development of clubhouses as a structure to deliver best practice integrated services is strongly encouraged.

- **Integrated Systems:** There are structures through which a number of the best practices can be offered and integrated. For example, as stated in the prior section, the Clubhouse models (PSR and Fountain House models) offer a structure for rehabilitation services and peer support. Another example used in a number of states is the *Community Support Program* service definition that includes a number of these components in a single blended, active service performed by provider organizations. Planning the integrated system includes closely examining the various best practice models and applying said models into corresponding structures for delivery. This further advances the notion of integration-- between provider organizations as well as within particular support and service structures.

G. Resources

The following would be helpful for additional Best Practice resources

1. Evidence Based Practice
http://mentalhealthpractices.org

2. For general reference see:
http://tecathsri.org/nimh-samhsa/nimh-samhsa-presentation.pdf

3. APA Practice Guidelines:

http://www.psych.org/clin_res/prac_guide.cfm

4. Center for Evidence Based Mental Health:
http://cebmh.warne.ox.ac.uk/cebmh/index.html

5. NY Office of Mental Health:
http://www.omh.state.ny.us/omhweb/aboutomh/Videos.html

6. National Guideline Clearinghouse:
http://www.guidelines.gov/index.asp

7. HSRI Evaluation Center:
http://www.tecathsri.org/knowledge.asp

8. University of Maryland:
http://www.hshsl.umaryland.edu/resources/evidence.html#SOCIALWORKME

9. Crisis Services:
www.emergencypsychiatry.org

10. Jail Diversion:
www.bazelon.org/decrim.html

11. The Cochrane Collaborative:
http://www.update-software.com/cochrane/abstract.htm

12. Behavioral Healthcare Resource Program:
http://ssw.unc.edu/bhrp

13. State of Tennessee Dept. of MH:
www.dualdiagnosis.org

14. Illness Self-Management:
www.bhrm.org/guidelines/illness-self-mgmt.pdf.

15. NAMI ACT Manual:
www.nami.org/about/pact.htm

16. Recovery Resources:
http://www.mentalhealth.org/consumersurvivor/recovery.asp

There are other resources that may not be available on-line, but nevertheless might serve as good resources. These include the following:

"The Dual Disorders Integrated Treatment Fidelity Scale" developed by Bob Drake, et al., at the New Hampshire – Dartmouth Psychiatric Research Center.

The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations developed by the Agency for Health Care Policy and Research, and the NIMH.

The Practice Guidelines for the Psychiatric Rehabilitation of Persons with severe and persistent mental illness in a Managed Care Environment developed by the International Association of Psychosocial Rehabilitation Services (IAPRS).

Questions regarding this correspondence should be directed to Ms. Bonnie Morell, Community Initiatives Branch Head, Adult Mental Health, Division of MHDDSAS, Mail Service Center 3014, Raleigh, NC 27699-3014. Ms. Morell can also be reached by telephone at (919)715-1294 or by e-mail at bonnie.morell@ncmail.net.

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